CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR MEDICAL GAS DISPENSER LICENSE
INSTRUCTION SHEET

When to File Application

This is the application for licensure of a facility that sells medical gases ***directly to patients*** in Delaware. However, if you are a facility that ***distributes*** medical gases to other facilities authorized to possess medical gases, instead of selling directly to patients, the correct application form is *Application for Distributor (Pharmacy-Wholesale)*.

File this application when applying for an initial license as a Medical Gas Dispenser OR re-applying when a previous Delaware license has lapsed and is no longer renewable. Since these licenses are not transferable, you must also file this application to report when a Medical Gas Dispenser already licensed in Delaware:

- Changes ownership (controlling interest), or
- Relocates

Requirements for *All* Applicants

Please read and follow instructions carefully. Failing to follow instructions will delay processing of your application.

☐ Submit completed, signed and notarized *Application for Medical Gas Dispenser License*.
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose non-refundable processing fee by check or money order made payable to the "State of Delaware."
- Applications submitted without the required fee will be rejected.

☐ Enclose a separate sheet showing this information for *each* owner or corporate officer listed on the application:

- Name
- Date of Birth
- Social Security Number
- Mailing Address

☐ Enclose one set (copy) of the plans for the dispenser facility.
- Plans must be drawn to scale and should show the area where medical gases will be dispensed, storage area, all entryways and security systems.
- Plans must also show the type of alarm system installed and the name, address, and phone of the provider.

Inspection Requirement

In addition to meeting all the requirements above, the medical gas dispenser facility must be inspected before opening. A representative of the facility ***must notify the Board office*** when the facility is ready for inspection. When the facility passes the final inspection, the Board office will issue the license.

Reporting a Name Change

If the medical dispenser facility's name changes but ***there is no change in ownership nor location***, it is not necessary to submit an *Application for Medical Gas Dispenser License.* Instead, submit:

☐ Letter notifying the Board of the change that includes the dispenser's old name, new name, license number and effective date of change.

☐ Duplicate license fee by check or money order made payable to the "State of Delaware."
- The duplicate license will show the new name, but the license number will not change.

For Board of Pharmacy Use Only
☐ Verification
☐ Background
☐ Office Approval
☐ Inspection

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APPLICATION FOR MEDICAL GAS DISPENSER LICENSE

TYPE OF APPLICATION

1. Select the items that describe the type of application:

   ☐ Initial Application –
   - ☐ This dispenser has never held a Delaware license.
   - ☐ This dispenser previously held Delaware license number **A2-** _____ that has lapsed and is no longer renewable.

   ☐ Application Due to Change of Ownership – Pharmacy license number **A2-** _____

   ☐ Application Due to Relocation – Pharmacy license number **A2-** _____

CONTACT AND LOCATION INFORMATION

2. Name of Business (as it should appear on license): _____

3. Enter all other trade or business names you use (or have used) such as "doing business as" or "formerly known as" names: _____ _____ _____

4. ***Location* Address**: _____
   Street (*No PO Boxes*) Note: If you are reporting relocation, this is the *new* location.

   _____ DE _____
   City State Zip

5. Phone: _____ Email: _____

6. ***Mailing* Address** (*if different from physical location*): _____

   _____ _____ _____
   City State Zip

7. Name of Person in Charge: _____ ☐ Owner ☐ Manager ☐ Other

OWNERSHIP INFORMATION

8. Type of Business Owner (check one):

   ☐ Sole Proprietor – Go to Question 9
   ☐ Individual with federal employee identification number – Go to Question 9.
   ☐ Partnership – **Skip to** Question 10.
   ☐ Corporation – Enter Date of Corporate Charter: _____ **Skip to** Question 10.

9. Enter the following information about the owner and then skip to Question 11.

   Full Name: _____

   Date of Birth: _____ Social Security Number: _____

   Mailing Address: _____

   _____ _____ _____
   City State Zip

10. If a partnership, list ***all active partners***. If a corporation, list ***all principal officers***.

FULL NAME	TITLE

Enclose a separate sheet showing name, date of birth, Social Security Number and mailing address for each person you listed above.

11. Do you understand that the Board must be notified within ten days of a change of ownership? Yes ☐ No ☐

PERSONNEL INFORMATION

12. Enter the following information about **all healthcare professionals** who will review verbal orders within 72 hours:

FULL NAME	DELAWARE LICENSE NUMBER

13. Have all personnel dispensing medical gases been trained to comply with the standards dictated by the U.S. Pharmacopoeia, Food and Drug Administration, Department of Transportation, Occupational Safety and Health Administration, Board of Pharmacy and any other applicable requirement under state and federal law or rules and regulations regarding storage, packaging, labeling, shipping, dispensing, transfilling, distributing and repackaging of medical gases? Yes ☐ No ☐

DISCLOSURES

14. Have any of the owners, corporate officers or healthcare professionals listed above ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which they have received a pardon, in any jurisdiction? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet and arrange for the Board office to receive a state and federal criminal background check for all persons.**

15. Are any of the owners, corporate officers or healthcare professionals listed above presently charged with committing a felony? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet**

16. Have any of the owners, corporate officers or healthcare professionals listed above ever applied for a medical gas dispenser license in any State and had the application denied? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet.**

17. Has any of the owners, corporate officers or healthcare professionals listed above ever been the subject of any disciplinary action (formal or informal) by any federal or state agency including, but not limited to, revocation or suspension of a license or registration or is any such action pending? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet and enclose any relevant documents.**

INFORMATION ABOUT SITE AND OPERATION

18. Enter Hours of Business Site:

Weekdays	_____ A.M. to _____ PM
Saturday	_____ A.M. to _____ PM
Sunday	_____ A.M. to _____ PM
Holidays	_____ A.M. to _____ PM

19. The storage and handling requirements of medical gases must follow the manufacturer's labeling requirements. Will the dispenser meet this requirement? Yes ☐ No ☐

20. Labeling of dispensed gases must include the manufacturer's label and a lot number on the cylinder in accordance with the federal Food, Drug and Cosmetic Act. Will the dispenser meet this requirement? Yes ☐ No ☐

21. Do the floor plans for the facility include the type of alarm system installed and the name, address, and phone number of the provider? Yes ☐ No ☐

22. The dispenser must maintain:
    - original of every order for a period of at least three years after the date of last dispensing
    - patient records that include at a minimum
        - name, address and phone of patient
        - name, address and phone of licensed practitioner
        - item and quantity dispensed
        - dispensing date

    Will the dispenser meet these recordkeeping requirements? Yes ☐ No ☐

Enclose a copy of the plans for the dispenser facility. Plans must be drawn to scale and should include the location of storage area, security systems, and all entryways.

When your application is <u>complete</u>, please allow 4-8 weeks to receive your permit. A <u>complete</u> application is one that includes all required documentation and correct payment.

Applications that are not <u>complete</u> within six (6) months of filing may be considered abandoned and discarded.

AFFIDAVIT

I hereby swear or affirm that the foregoing statements are correct and do hereby agree to abide by the pharmacy laws of the State of Delaware and to all rules and regulations of the Delaware State Board of Pharmacy.

Signature:_____ Date: _____

Print Name:_____ Position: _____

State: _____ County: _____

Sworn or affirmed before me a Notary Public this_____ day of _____ 2_____

Notary Public: _____

SEAL

My commission expires on _____

APPLICATIONS THAT ARE NOT SIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.